Learning from Deaths

There is a new national process for reviewing care of patients who die in hospital aged 18 or above. This is aimed at improving care and reducing the risk of future adverse events.

- The treating consultant will continue to undertake the initial review using a new proforma (now appears on Notify) which includes a rating for overall care.
- All those cases where harm has been caused by healthcare should have a DATIX completed and be reported as a SI.
- If the overall care is identified as poor then a second level review called a Structured Judgement Casenote Review (SJCR) will be commissioned, this will be performed by an independent consultant who has been specifically trained in the methodology and clear action plans will be developed.

Training is available in the Trust and information about the process is available at: [https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources](https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources)

**There are also some patients who will automatically require a SJCR.** These include:

- patients with learning difficulties or severe mental health problems
- patients who die after elective admission
- patients whose relatives or carers raise serious concerns about the treatment they received.

Bereaved relatives will be informed that this process is ongoing and will have a right to have a summary of the report.

**It is crucial that all teams engage in this process and the details are available in the new Learning from Death Policy available at:** [http://staffroom.ydh.yha.com/policies-and-procedures/corporate-policies-and-procedures/mortality-learning-from-deaths-policy/view](http://staffroom.ydh.yha.com/policies-and-procedures/corporate-policies-and-procedures/mortality-learning-from-deaths-policy/view)

If you require any support or have any concerns about the process then please contact:

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